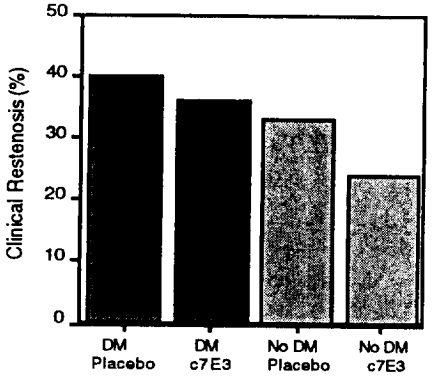
bolus and infusion had a 36% rate of clinical restenosis (CR). Patients without diabetes had a lower rate of restenosis whether receiving placebo (CR = 33%) or c7E3 (CR = 24%). In regression analysis, diabetes was the only baseline clinical feature associated with an increased event rate (hazard ratio 1.44, p = 0.001). Among patients without diabetes, the relative risk of major bleeding events was 2.6 times higher for those receiving c7E3 compared to placebo (9.9% vs. 3.7%, respectively). This effect was doubled among diabetics (12.9% vs. 2.2%, relative risk = 5.8). In conclusion, these data importantly confirm the higher clinical restenosis among diabetics and demonstrate a marked propensity to major bleeding events among diabetics treated with potent platelet antagonists.



935-35 Results of Stent Implantation for Diffuse Coronary Disease Assisted by Intravascular Ultrasound

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The long term benefit of elective Palmaz-Schatz stent implantation for focal lesions in large vessels has been clearly delineated. The elective use of stents in diffuse disease, however, has not been fully evaluated. This study reports on the use of stents in 89 pts with 108 lesions (les) with diffuse disease. Diffuse disease was defined as a lesion length longer than 20 mm. After a successful angiographic result was obtained, intravascular ultrasound (IVUS) was performed to confirm optimal stent expansion and lesion coverage and to guide further balloon dilation and stent implantation. The mean age was 57 ± 10. Mean lesion length was 32 ± 6 mm. Vessel distribution was 51 LAD (47%), 45 RCA (42%), 10 LCX (9%), and 2 vein graft (2%). Lesion location was 49 proximal (45%), 52 mid (48%), and 7 distal (7%). 274 stents were implanted (139 Palmaz-Schatz, 34 short (7 mm) Palmaz-Schatz, 48 Gianturco-Roubin, and 53 Wiktor) for an average of 2.4 ± 1.4 stents/lesion. Procedure success was achieved in 83 patients (93%). Procedure associated complications included 3 myocardial infarction (3%) and 3 emergency bypass (3%) and 1 elective bypass (1%). Following the procedure, 77 pts (93%) with 94 les were treated only with antiplatelet therapy and no anticoagulation. Angiographic follow up at 4–6 months was performed on 49 of the eligible 65 lesions (71%). Baseline, final and follow up angiographic (AG) results are below:

AG Results	Reference (mm)	MLD (mm)	% Stenosis
Baseline	3.11 ± 0.47	0.66 ± 0.58	79 ± 19
Post Stent	3.09 ± 0.50	3.01 ± 0.47	3 ± 12
Follow Up	3.01 ± 0.48	1.80 ± 0.91	40 ± 28

There was 1 acute stent thrombosis event (1.2%). Restenosis by 50% diameter stenosis criteria was present in 17 of 49 lesions (35%) and 13 of 39 patients (34%).

Conclusions. (1) Stent Implantation in diffuse disease that is assisted by IVUS is associated with acceptable procedure complication rate and a low stent thrombosis rate despite the absence of post stent anticoagulation in the majority of patients. (2) The restenosis rate of 35% appears to represent an improvement over the reported restenosis rates for diffuse disease after angioplasty or other devices.

935-36 Mechanism of Benefit of Stenting in Failed PTCA. Final Results from the Trial of Angioplasty and Stents in Canada (TASC II)

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TASC II is a randomised multicentre study comparing the strategies of stenting (n = 21) and prolonged perfusion balloon inflation (PPB; n = 22) as initial bail-out therapy in failed PTCA. Core lab qualitative and quantitative angiography analysis was possible in 40/43 patients.

Results.

	Pre randomisation		Post Randomisation			
	MLD (mm)	%	MLD (mm)	%	Success	Recoil (mm)
Stent n = 21	1.1 ± 0.5	59 ± 17	2.2 ± 0.4	20 + 11	90% 19/21	0.32 ± 0.35
PPB n = 19	1.2 ± 0.6	60 ± 18	1.5 ± 0.3	46 + 23	42% 8/19	0.96 ± 0.54
P	ns	ns	<0.001	<0.001	0.002	<0.001

1) *Stenting was more effective as bail-out therapy* (90% vs 42% p < 0.002), especially in treating dissections of grade C or above: stent 11/12 (91%) vs PBB (0/5 (0)% p < 0.0001).

2) *Angiographic results with successful PPB were inferior to stenting:* % stenosis: 30.6 ± 20.2; MLD 1.9 ± 0.3 (p < 0.05 cf stent MLD) due to greater recoil in the PPB group: PPB 0.66 ± 0.34 mm (p < 0.05 cf stent recoil).

3) *Stenting following failed PPB was successful in 9/10 attempts with equivalent angiograms results to primary stent bail-out:* % stenosis 24.8 ± 8.2; MLD 2.5 ± 0.4 mm, but procedure time was longer 152.6 ± 53.0 mins v 114.8 ± 31.3 mins (p < 0.05).

Summary. This randomised multicentre study of bailout therapy in failed PTCA confirms the benefit of stenting in improving immediate results by reducing elastic recoil and sealing complex dissections. Crossover to stenting following failed PPB gives angiographic results comparable to primary bail-out stenting at the expense of increased lab time.

935-37 The Trial of Angioplasty and Stents in Canada: Clinical Outcome

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The trial of angioplasty and stents in Canada (TASC I) compared the strategy of coronary artery stenting (S) to PTCA in de novo (de N = 149) and restenosis (R = 121) lesions with a 1° end point of angiographic restenosis and 2° end point of event free survival at 6 months.

Results:

	De novo		Restenosis		Total	
	S (76)	PTCA (73)	S (61)	PTCA (60)	S (137)	PTCA (133)
Death	0 (0%)	1	0	0	0	1
MI	7	1	3	0	10	1
CABG	2	1	0	2	2	3
Repeat Interven.	3	5	1	5	4	10
Event free Survival	64 (84%)	65 (89%)	57 (93%)	53 (88%)	121 (88%)	118 (89%)

There was a reduction of clinical events in patients with restenosis lesions treated by stenting as compared to de novo lesions: 6.6% vs 15.8% p = 0.094. There was an increased early (less < 40 days) infarct rate in the stented patients due to stent thrombosis and a trend towards decreased intervention in target lesions at 6 months (p = 0.088).

Conclusion: The strategies of coronary artery stenting in this study had equivalent of event free survival to STRESS and Benestent in de novo lesions. Patients who underwent stenting for restenosis lesions had an improved outcome with only a 7% cardiac event rate at 6 months.

935-38 Restenosis After Coronary Angioplasty is Associated with the Activation Status of Circulating Phagocytes Before Treatment

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Background. The purpose of this study was to identify biological risk factors for restenosis after PTCA, in order to predict the long-term outcome of PTCA before treatment.

Methods and Results. To investigate whether blood granulocytes and monocytes could determine luminal renarrowing after PTCA, several characteristics of these phagocytes were assessed before angioplasty in 32 patients who underwent PTCA of one coronary artery and who had repeat angiograms at six months follow-up. The plasma levels IL-1β, TNF-α, IL-6, fibrinogen, C-reactive protein and LP(a) before angioplasty were assessed as well. We found that the expression of the membrane antigens CD64, CD66 and CD67 by granulocytes was inversely associated with the luminal renarrowing normalized for vessel size (relative loss) at six months after PTCA, while the production of IL-1β by stimulated monocytes was positively associated with the relative loss. Next, these univariate predictors were corrected